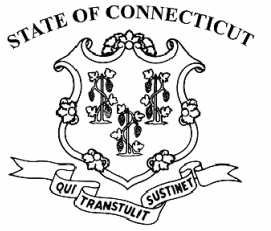

Substitute House Bill No. 5157

Public Act No. 08-181

AN ACT CONCERNING THE MARKETING OF MEDICAL DISCOUNT PLANS, THE ISSUING OF SMALL EMPLOYER PLANS AND ARRANGEMENTS BY THE COMPTROLLER AND ASSOCIATION GROUPS, AND AN OFFSET OF THE ANNUAL STANDARD PREMIUM REQUIRED OF WORKERS' COMPENSATION SELF-INSURANCE GROUPS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-479qq of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(a) As used in this section and section 38a-479rr, as amended by this act:

(1) "Affiliate" means a person that directly or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, a health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society licensed in this state;

(2) "Consumer" means: (A) A person to whom a medical discount plan is marketed or advertised, or (B) a member, as defined in this subsection;

(3) "Marketer" means a person that markets, advertises or sells a

medical discount plan, including, but not limited to, an entity that markets, advertises or sells a medical discount plan under its own name;

[(3)**]** (4) "Medical discount plan" means a business arrangement or contract in which a person, in exchange for payment, provides access for its members to providers of health care services and the right to receive health care services from those providers at a discount. "Medical discount plan" does not include a product that (A) is otherwise subject to regulation or approval under this title, or (B) costs less than twenty-five dollars, annually, in the aggregate;

[(4)**]** (5) "Medical discount plan organization" means a person that (A) establishes a medical discount plan, (B) contracts with providers, provider networks or other medical discount plan organizations to provide health care services at a discount to medical discount plan members, and (C) determines the fees charged to the members for the medical discount plan. "Medical discount plan organization" does not include a health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society licensed in this state or any affiliate of such health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society;

[(5)**]** (6) "Health care services" means any care, service or treatment of an illness or dysfunction of, or injury to, the human body. "Health care services" includes physician care, inpatient care, hospital surgical services, emergency medical services, ambulance services, dental care services, vision care services, mental health care services, substance abuse services, chiropractic services, podiatric services, laboratory test services and the provision of medical equipment or supplies. "Health care services" does not include pharmaceutical supplies or prescriptions;

[(6)**]** (7) "Member" means an individual who pays for the right to receive the benefits of a medical discount plan; and

[(7)**]** (8) "Person" means a person, as defined in section 38a-1.

(b) No person **[**may**]** shall market, advertise or sell to a resident of this state a medical discount plan or any plan material that: (1) Fails to provide to the consumer a clear and conspicuous disclosure that the medical discount plan is not insurance and that the plan only provides for discounted health care services from participating providers within the plan; (2) uses in its marketing materials, advertisements, brochures or member discount cards the term "insurance", "health plan", "coverage", "copay", "copayments", "preexisting conditions", "guaranteed issue", "premium", "PPO", "preferred provider organization" or any other term that could reasonably mislead a person into believing the medical discount plan is insurance, except that such terms may be used as a disclaimer of any relationship between the medical discount plan and insurance; (3) fails to provide the name, address and telephone number of the administrator of the medical discount plan; (4) fails to make available to the consumer through a toll-free telephone number, upon request of the consumer, a complete and accurate list of the participating providers within the plan in the consumer's local area and a list of the services for which the discounts are applicable; (5) fails to make a printed copy of such list available to the consumer upon request commencing with the time the plan is purchased or fails to update the list at least once every six months; (6) fails to use plain language to describe the discounts or access to discounts offered and such failure results in representations of the discounts that are misleading, deceptive or fraudulent; (7) fails to provide the consumer notice of the right to cancel such medical discount plan; (8) offers discounted health care services or products that are not authorized by a contract with each provider listed in conjunction with the medical discount plan; (9) fails to allow a

consumer to cancel a medical discount plan not later than thirty days after the date payment is received by the medical discount plan; (10) with respect to a consumer who cancels a medical discount plan pursuant to subdivision (9) of this subsection, fails to guarantee a refund of all membership fees paid to the medical discount plan by the consumer, excluding a reasonable one-time processing fee, not later than thirty days after the member gives timely notification of cancellation of the plan to the medical discount plan organization; or (11) fails to (A) provide at least one member discount card for each member as proof of membership, and (B) prominently display on such member discount card a statement that the medical discount plan is not insurance.

(c) Any person who knowingly operates as a medical discount plan organization in violation of this section shall be fined not more than ten thousand dollars. Any person who knowingly aids and abets another that the person knew or reasonably should have known was operating as a medical discount plan organization in violation of this section shall be fined not more than ten thousand dollars.

(d) Any person who collects fees for purported membership in a medical discount plan but fails to provide the promised benefits shall be subject to the penalties for larceny under sections 53a-122 to 53a-125b, inclusive, depending on the amount involved. Upon the conviction of such person of larceny, as defined in section 53a-119, if the court does not order financial restitution pursuant to section 53a-28, the commissioner may order reimbursement of any membership fees paid by residents of the state who were harmed by such offense.

(e) Any person licensed in this state as a health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society, or any affiliate owned or controlled by such health insurer, health care center, hospital service corporation, medical service corporation or fraternal benefit society, may offer medical

discount plans in this state pursuant to such licensure.

Sec. 2. Section 38a-479rr of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(a) Before doing business in this state as a medical discount plan organization, an entity shall:

(1) Be a corporation, limited liability company, limited liability partnership, or other legal entity organized under the laws of this state or, if a foreign corporation or other foreign entity, authorized to transact business in this state; and

(2) Obtain a license as a medical discount plan organization from the Insurance Commissioner in accordance with this section. The entity shall file an application for a license to operate as a medical discount plan organization with the commissioner on such form as the commissioner prescribes. Such application shall be sworn to by an officer or authorized representative of the applicant, under penalty of false statement, and be accompanied by (A) a copy of the applicant's articles of incorporation, including all amendments; (B) a copy of the applicant's bylaws; (C) a list of the names, addresses, official positions and biographical information of the medical discount plan organization and the individuals who are responsible for conducting the applicant's affairs, including, but not limited to, all members of the board of directors, board of trustees, executive committee, or other governing board or committee, the officers, contracted management company personnel, and any person or entity owning or having the right to acquire ten per cent or more of the voting securities of the applicant, which listing shall fully disclose the extent and nature of any contracts or arrangements between the applicant and any individual who is responsible for conducting the applicant's affairs, including any possible conflicts of interest; (D) for each individual listed in subparagraph (C) of this subdivision as being responsible for

conducting the applicant's affairs, a complete biographical statement on forms prescribed by the commissioner; (E) a statement generally describing the applicant, its personnel and the health care services to be offered; (F) a copy of the form of all contracts made or to be made between the applicant and any providers or provider networks regarding the provision of health care services to members; (G) a copy of the form of any contract made or to be made between the applicant and any person listed in subparagraph (C) of this subdivision; (H) a copy of the form of any contract made or to be made between the applicant and any person for the performance on the applicant's behalf of any function, including, but not limited to, marketing, administration, enrollment and subcontracting for the provision of health care services to members; (I) a copy of the applicant's most recent financial statements audited by an independent certified public accountant, or, in the case of an applicant that is a subsidiary of a person or parent corporation that prepares audited financial statements reflecting the consolidated operations of the person or parent corporation, a copy of the person's or parent corporation's most recent financial statements audited by an independent certified public accountant, provided the person or parent corporation also issues a written guarantee that the minimum capital requirements of the applicant required by this section will be met; (J) a description of the proposed method of marketing; (K) a description of the subscriber complaint procedures to be established and maintained; **[**and**]** (L) the fee for a medical discount plan organization license set forth in section 38a-11 of the 2008 supplement to the general statutes; and (M) a list of the names, addresses and telephone numbers of the marketers the applicant has authorized to market a medical discount plan in this state under a name that is different from the name of the applicant. For purposes of this subdivision, a "contract to be made" shall be determined based on the information known to the applicant on the date the information is filed with the commissioner.

(b) (1) A current and accurate list of authorized marketers, specified in subparagraph (M) of subdivision (2) of subsection (a) of this section, shall be submitted to the commissioner with each renewal fee, as set forth in subsection (c) of this section.

(2) Any change made to the list of authorized marketers, specified in subparagraph (M) of subdivision (2) of subsection (a) of this section, shall be electronically filed with the commissioner. If such change is to add a marketer to a medical discount plan organization's list of authorized marketers, such change shall be electronically filed by such organization prior to the marketer doing business in the state for such organization.

(3) The commissioner may adopt regulations, in accordance with chapter 54, to establish the procedure and format of the electronic filing and acknowledgment set forth in this subsection.

[(b)**]** (c) If the commissioner finds that the applicant is in compliance with the requirements of this section the commissioner shall issue the applicant a license as a medical discount plan organization which shall expire one year after the date of issue. The commissioner shall renew the license if the commissioner finds that the licensee is in compliance with the requirements of this section and the licensee has paid the renewal fee set forth in section 38a-11 of the 2008 supplement to the general statutes.

[(c)**]** (d) Prior to applying for a license from the commissioner, a medical discount plan organization shall establish an Internet web site that contains the information described in subsection **[**(r)**]** (s) of this section.

[(d)**]** (e) Any license or renewal fee received pursuant to this section shall be deposited in the Insurance Fund established in section 38a-52a.

[(e)**]** (f) Nothing in this section shall require a provider who

provides discounts to the provider's own patients to obtain or maintain a license as a medical discount plan organization.

[(f)**]** (g) Each provider who offers health care services to members under a medical discount plan shall provide such services pursuant to a written agreement. The agreement may be entered into directly by the provider or by a provider network to which the provider belongs.

[(g)**]** (h) A provider agreement shall include: (1) A list of the services and products to be provided at a discount; (2) the amount of the discounts or, alternatively, a fee schedule that reflects the provider's discounted rates; and (3) a requirement that the provider will not charge members more than the discounted rates.

[(h)**]** (i) A provider agreement between a medical discount plan organization and a provider network shall require that the provider network have written agreements with its providers that: (1) Contain the terms set forth in subsection **[**(g)**]** (h) of this section; (2) authorize the provider network to contract with the medical discount plan organization on behalf of the provider; and (3) require the network to maintain an up-to-date list of its contracted providers and to provide that list on a quarterly basis to the medical discount plan organization. No medical discount plan organization may enter into or renew a contractual relationship with a provider network that is not licensed in accordance with section 38a-479aa of the 2008 supplement to the general statutes.

[(i)**]** (j) The medical discount plan organization shall maintain a copy of each active agreement that it has entered into with a provider or provider network.

[(j)**]** (k) Each medical discount plan organization shall at all times (1) maintain a net worth of at least two hundred fifty thousand dollars, or (2) post a surety bond in the amount of one hundred thousand dollars.

[(k)**]** (l) The commissioner **[**may**]** shall not issue or renew a license under this section unless the medical discount plan organization has (1) a net worth of at least two hundred fifty thousand dollars, or (2) posted a surety bond in the amount of one hundred thousand dollars.

[(l)**]** (m) The commissioner may suspend the authority of a medical discount plan organization to enroll new members, revoke any license issued to a medical discount plan organization, refuse to renew a license of a medical discount plan organization or order compliance if the commissioner finds that any of the following conditions exist:

(1) The organization is not operating in compliance with this section or section 38a-479qq, as amended by this act;

(2) The organization does not have the minimum net worth required by this section;

(3) The organization has advertised, sold or attempted to sell its services in such a manner as to misrepresent its services or capacity for service or has engaged in deceptive, misleading or unfair practices with respect to advertising or sales;

(4) The organization is not fulfilling its obligations as a medical discount plan organization; or

(5) The continued operation of the medical discount plan organization would be hazardous to its members.

[(m)**]** (n) If the commissioner has reasonable cause to believe that grounds for the suspension, nonrenewal or revocation of a license exist, the commissioner shall notify the medical discount plan organization in writing specifically stating the grounds for suspension, nonrenewal or revocation.

[(n)**]** (o) When the license of a medical discount plan organization is

surrendered, nonrenewed or revoked, the organization shall, immediately following the effective date of the order, wind up and settle the affairs transacted under the license. The organization **[**may**]** shall not engage in any further marketing, advertising, sales, collection of fees or renewal of contracts as a medical discount plan organization, and its authorized marketers shall not engage in any further marketing, advertising or sales on behalf of such medical discount plan organization.

[(o)**]** (p) The commissioner shall, in any order suspending the authority of a medical discount plan organization to enroll new members, specify the period during which the suspension is to be in effect and the conditions, if any, which must be met by the medical discount plan organization prior to reinstatement of its license to enroll new members. The commissioner may rescind or modify the order of suspension prior to the expiration of the suspension period.

[(p)**]** (q) The commissioner **[**may**]** shall not reinstate a license: (1) Unless reinstatement is requested by the medical discount plan organization, and (2) if the commissioner finds that the circumstances which led to the suspension still exist or are likely to recur.

[(q)**]** (r) Each medical discount plan organization shall provide the commissioner at least thirty days' advance written notice of any change in the medical discount plan organization's name, address, principal business address or mailing address.

[(r)**]** (s) Each medical discount plan organization shall maintain an up-to-date list of the names and addresses of the providers with which it has contracted on an Internet web site, the address of which shall be prominently displayed on all its marketing materials, advertisements, brochures and member discount cards. The list shall include providers with whom the medical discount plan organization has contracted directly as well as providers who will provide services to the

organization's members as part of a provider network with which the medical discount plan organization has contracted.

[(s)**]** (t) Each medical discount plan organization shall (1) prominently display on any member discount card the names or identifying logos or trademarks of any provider networks with whom the medical discount plan organization has a contract, and (2) provide the names of such provider networks to members upon request.

(u) No marketer shall market, advertise or sell to a resident of this state a medical discount plan under a name that is different than the medical discount plan organization's name unless: (1) The medical discount plan organization has obtained a license from the Insurance Commissioner in accordance with this section; (2) the marketer is listed on such medical discount plan organization's list of authorized marketers as set forth in subparagraph (M) of subdivision (2) of subsection (a) or subsection (b) of this section; (3) the name, address and telephone number of the medical discount plan organization appears on the plan materials; and (4) the marketer does not contract directly with providers or provider networks. A marketer shall not be required to obtain a license from the commissioner.

(v) (1) A medical discount plan organization may market directly or contract with marketers for the distribution of a medical discount plan. The medical discount plan organization shall execute a written agreement with a marketer and comply with the requirements set forth in subparagraph (M) of subdivision (2) of subsection (a) or subsection (b) of this section, as applicable, prior to the marketing, advertising or selling of such medical discount plan by such marketer. Such written agreement shall prohibit the marketer from using any advertising and marketing materials, including, but not limited to, brochures and medical discount plan cards, without the written approval of the medical discount plan organization prior to the usage of such advertising and marketing materials.

(2) If a marketer uses any marketing or advertising materials that are in violation of subsection (b) of section 38a-479qq, as amended by this act, the commissioner may order a medical discount plan organization to immediately remove such marketer from such medical discount plan organization's list of authorized marketers specified in subparagraph (M) of subdivision (2) of subsection (a) of this section. In addition, the commissioner may order the medical discount plan organization to return membership fees paid by residents of the state who were harmed by such violation.

(3) During an investigation by the commissioner of an alleged violation set forth in subdivision (2) of this subsection, a medical discount plan organization shall make available to the commissioner, upon request, a copy of such organization's contract with such marketer, and any marketing and advertising materials of such marketer.

(w) Each medical discount plan organization that contracts with a marketer shall be bound by and responsible for the activities of such marketer, within the scope of the marketer's agency relationship, and shall cooperate in any investigation of the activities of such contracted marketer as ordered by the commissioner.

[(t)**]** (x) The commissioner may adopt regulations, in accordance with chapter 54, to implement the provisions of this section.

[(u)**]** (y) Any person who violates any provision of this section shall be fined not more than two thousand dollars.

Sec. 3. Subdivision (22) of section 38a-567 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(22) (A) With respect to plans or arrangements issued pursuant to subsection (i) of section 5-259 of the 2008 supplement to the general

statutes, **[**or by an association group plan,**]** at the option of the Comptroller, **[**or the administrator of the association group plan,**]** the premium rates charged or offered to small employers purchasing health insurance shall not be subject to this section, provided **[**(A)**]** (i) the plan or plans offered or issued cover such small employers as a single entity and cover not less than **[**ten**]** three thousand **[**eligible individuals**]** employees on the date issued, **[**(B)**]** (ii) each small employer is charged or offered the same premium rate with respect to each **[**eligible individual**]** employee and dependent, and **[**(C)**]** (iii) the plan or plans are written on a guaranteed issue basis.

(B) With respect to plans or arrangements issued by an association group plan, at the option of the administrator of the association group plan, the premium rates charged or offered to small employers purchasing health insurance shall not be subject to this section, provided (i) the plan or plans offered or issued cover such small employers as a single entity and cover not less than three thousand employees on the date issued, (ii) each small employer is charged or offered the same premium rate with respect to each employee and dependent, and (iii) the plan or plans are written on a guaranteed issue basis. In addition, such association group (I) shall be a bona fide group as set forth in the Employee Retirement and Security Act of 1974, (II) shall not be formed for the purposes of fictitious grouping, as defined in section 38a-827, and (III) shall not issue any plan that shall cause undue disruption in the insurance marketplace, as determined by the commissioner.

Sec. 4. Subsection (b) of section 38a-1003 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective October 1, 2008*):

(b) To obtain and to maintain its certificate of approval, a workers' compensation self-insurance group shall comply with the following requirements as well as any other requirements established under the

provisions of chapter 568. Such group shall have:

(1) A combined net worth of all members of a group of private employers of at least five million dollars. Such group shall maintain a minimum working capital of two hundred fifty thousand dollars. The minimum premium or portion thereof required in subdivision (1) of subsection (a) of section 38a-1017 shall be used to satisfy the working capital requirements of this section.

(2) A security, in the amount of five hundred thousand dollars or more and such security shall be in the form of a surety bond, security deposit or financial security endorsement or any combination thereof. If a surety bond is used to meet the security requirement, it shall be issued by a corporate surety company authorized to transact business in this state. If a security deposit is used to meet the security requirement, such securities shall be limited to bonds or other evidence or indebtedness issued, assumed or guaranteed by the United States of America or by an agency or instrumentality thereof; certificates of deposit in a federally insured bank; shares or savings deposits in a federally insured savings and loan association or credit union; or any bond or security issued by a state of the United States of America and backed by the full faith and credit of the state. Any such securities shall be deposited with the State Treasurer and assigned to and made negotiable by the chairman of the Workers' Compensation Commission pursuant to a trust document acceptable to the commissioner. Interest accruing on a negotiable security so deposited shall be collected and transmitted to the depositor provided the depositor is not in default. A financial security endorsement, issued as part of an acceptable excess insurance contract, may be used to meet all or part of the security requirement. The bond, security deposit or financial security endorsement shall be: (A) For the benefit of the state solely to pay claims and associated expenses; and (B) payable upon the failure of the group to pay workers' compensation benefits that it is

legally obligated to pay. The commissioner may establish and adjust from time to time, requirements for the amount of security based on differences among groups in their size, types of employment, years in existence and other relevant factors.

(3) Specific and aggregate excess insurance in a form, in an amount, and by an insurance company acceptable to the commissioner. The commissioner may establish minimum requirements for the amount of specific and aggregate excess insurance based on differences among groups in their size, types of employment, years in existence and other relevant factors, and may permit a group to meet this requirement by placing in a designated depository securities of the type referred to in subdivision (2) of this subsection.

(4) An estimated annual standard premium of at least one million dollars during a group's first year of operation and annually thereafter. Such amount may be offset or reduced by depositing equivalent liquid assets in an interest-bearing claims reserve account established in the name of the proposed workers' compensation self-insurance group. Such proposed workers' compensation self-insurance group shall not pledge, hypothecate or otherwise encumber its assets to secure its debt, guaranty or obligations. No single member applicant shall have more than twenty per cent of the total combined standard premium of the group.

(5) An indemnity agreement jointly and severally binding the group and each member thereof to meet the workers' compensation obligations of each member. The indemnity agreement shall be in a form prescribed by the commissioner and shall include minimum uniform substantive provisions prescribed by the commissioner. Subject to the commissioner's approval, a group may add other provisions as are necessary to perform its obligations.

(6) A fidelity bond for the administrator in a form and amount

prescribed by the commissioner.

(7) A fidelity bond for the service company in a form and amount prescribed by the commissioner. The commissioner may also require the service company providing claim services to furnish a performance bond in a form and amount he prescribes.

Sec. 5. Subsection (c) of section 38a-505 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The commissioner shall adopt regulations, in accordance with chapter 54, to establish minimum standards for benefits under each of the following categories of coverage in individual policies, other than conversion policies issued pursuant to a contractual conversion privilege under a group policy: Basic hospital expense coverage, basic medical-surgical expense coverage, hospital confinement indemnity coverage, major medical expense coverage, disability income protection coverage, accident only coverage, **[**and**]** specified accident coverage and specified disease coverage. **[**Specified disease policies, riders and benefits shall be prohibited whether issued on a group or individual basis, except as provided in section 38a-457, or as determined by the commissioner provided the commissioner, prior to permitting any sale of such policies, adopts regulations in accordance with chapter 54 to establish minimum standards for benefits in such specified disease policies, certificates, riders, endorsements and benefits.**]**

Sec. 6. Section 38a-513 of the general statutes is amended by adding subsection (d) as follows (*Effective from passage*):

(NEW) (d) Not later than January 1, 2009, the commissioner shall adopt regulations, in accordance with chapter 54, to establish minimum standards for benefits in group specified disease policies,

certificates, riders, endorsements and benefits.

Sec. 7. Subsection (c) of section 38a-554 of the 2008 supplement to the general statutes is repealed and the following is substituted in lieu thereof (*Effective from passage*):

(c) The commissioner shall adopt regulations, in accordance with chapter 54, concerning coordination of benefits between the plan and other health insurance plans. No individual or group health insurance plan shall coordinate benefits or otherwise reduce benefit payments because a person is covered by or receives benefits from a group specified disease policy delivered, issued for delivery, renewed, amended or continued in this state.

Approved June 12, 2008